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EDWARD J. BIRMINGHAM, M. D., EDITOR.

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ARCHIVES OF CLINICAL SURGERY.

VOL. II,

APRIL, 1877.

NO. I.

ORIGINAL PAPERS.

SIMPLIFICATION OF ORTHOPEDIC APPARATUS.

BY

EDMUND ANDREWS, A. M. M. D.,
Professor of Surgery in Chicago Medical College.

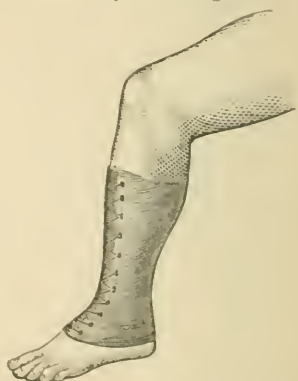
Orthopedic Surgery is encumbered more than any other branch of our art with an unnecessary complexity of apparatus. Very often the brace ordered by the surgeon is absolutely and utterly beyond the pecuniary ability of the distressed patient, and not unfrequently, when purchased, it proves so complicated that the family physician to whom the patient returns after visiting the city surgeon, neither comprehends, nor can successfully manage the terrible machine.

Before this branch of surgery can attain its proper usefulness it must attain to a higher perfection in simplicity, cheapness, and comprehensibility, and lay away among the paraphernalia of old torture chambers, very many of the appliances heretofore used.

New inventions are apt to be complex. It is only as we approach perfection that we attain to simplicity. Even in little things we find good illustrations of this principle. Not many years ago, surgeons dotted their apparatus all over with buckles in the manner of harness makers. It was only after years of experience that it dawned on the whole profession simultaneously that a strap can be buttoned upon a simple knob far more easily and quickly than it can be put into a buckle. The thought seemed to come to everybody at once, and now the buckles have almost disappeared.

One of the most complex and troublesome pieces of apparatus in use, is the one generally made to extend inflamed ankle-joints. It is effectual, but it is costly, cumbersome, and rather tedious to apply. For

some years I have used with the greatest satisfaction, and excellent results, a much simpler device. The following cut gives a correct idea of it. The top of the foot and the lower half of the leg constitute two cones whose apices meet at the ankle. Now if any moderately firm and well fitting material surround these parts and be laced together with some firmness, the two cones will be pressed apart, and extension of the ankle secured, or to put it in different terms, the inverted cone laced to the leg is a counter extending force, while the lacing together of the hollow cone embracing the upper surfaces of the foot tend to push that member downward, and thus makes extension upon the joint. To construct this a plaster cast should be taken of the foot and leg, with the foot hanging free and pointing downward somewhat. This position is found by experience to be much the best. A piece of wet russet harness leather is wrapped around the cast and crimped to a perfect fit by winding a stout cord, or a piece of webbing all over it. The leather laps over itself in front. After a few hours drying in an oven, or on a stove, the leather hardens and retains its shape. Before applying the leather, a little building out of the malleoli of the cast should be done with plaster of Paris, that the leather may be well moulded out, and not press painfully on those prominences. Eyelets are set in the overlapping edge, and in a strip of leather sewed to the part opposite it so as to allow of lacing it up to any desired tightness. The eyeletted edges of the leather should be wider apart on the dorsum of the foot than elsewhere, as owing to the yielding of that member, the edges lace together more than on the leg. The brace is finished by pasting in a chamois leather lining. It fits the limb like wax, keeps up a gentle and desirable pressure on the joint, maintains immobility and pushes down the foot so as to make an effective extension of the ankle-joint. No screws, racks and pinions, nor even adhesive straps are required. The action of the instrument has pleased me beyond measure by its simplicity, the ease with which it can be taken off and re-applied, and its efficiency in curing the inflammation.



The same principle can be temporarily carried out by means of a dextre splint open behind, and compressed by an elastic bandage, or even by a common roller.

I have also found great satisfaction in simplified braces for inflamed

knee-joints.

If the knee can still be straightened I apply the following apparatus.

The leather lacer at the top spreads its pressure over a wide surface and also spreads out somewhat upon the bulge of the nates, so that hardly a perceptible pressure is exerted upon the veins at any one point; scarcely any, hence there is little or no tendency to that venous congestion and swelling of the parts below, which authors say the ordinary apparatus produces if no bandage is used, yet I think that the practice of employing a compression bandage is useful to the knee, even if no tendency to swelling exists.

EXTENSION SPLINT FOR INFLAMED KNEE IN THE
STRAIGHT POSITION.

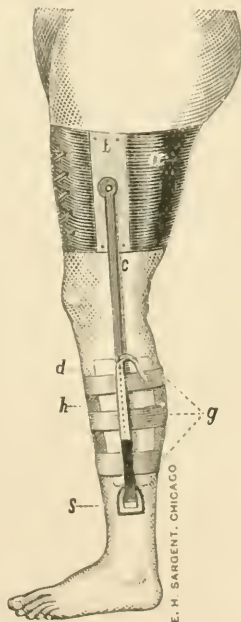
- a.* Leather, laced in front.
- b.* Steel Plate, riveted to each side.
- c.* Rod, terminating in slot *s*. A similar rod is on the other side of the limb.
- s.* Slot, with a friction roller.
- g.* Adhesive Straps, to the lower end of which an elastic band is sewn.
- h.* Elastic Band, terminating in a leather strap, which is passed through the slot *s* and turned up, and, being strongly stretched, is buttoned to a knob, *d*.

MEASUREMENTS REQUIRED.

1. Circumference of thigh close to bulge of nates.
2. Circumference of thigh one inch above top of patella.
3. Distance of these two circumferences from each other.
4. Distance from upper circumference to a point two inches above lower end of malleolus.

The rod *c* is much slenderer than represented in the engraving, and is loosely jointed to the steel plate *b*. The broad perpendicular adhesive strap should terminate a little above the slot *s*. To the lower end a stout elastic band is sewn, a few inches long, and of the kind used by some wooden-leg makers for springs. A leather strap is sewn to the elastic.

The opposite side of the limb is armed in the same way. The hip leather being laced on, the strap and elastic bands carried down to the slot *s* whose upper border is made by a little friction roller that the band



may run easily. The strap being drawn through the slot, is then stretched firmly upward by the hand and buckled to the knob *d*. It will be observed that while at first glance this may seem to be pulling up instead of downward, yet the fact is, the elastic in passing under the friction roller changes its direction and in fact, pulls strongly downward on the adhesive plaster and the limb to which it is attached. The same maneuver repeated on the opposite side doubles the force of the extension. The use of the elastic bands is not strictly necessary. A double tape carried through the slot and tied over the knob is simpler, and if properly attended to, is equally efficient; but the elastic is convenient, because in any yielding or stretching of the dressings its contractibility still keeps up the tension without requiring so much watchfulness on the part of the surgeon. Elastic bands were in common use fifteen years ago, but of late have been much neglected. If occasion demands it, the surgeon can easily construct an extempore form of this splint, using simply leather, wood, and a few screws, and putting them together with his own hands.

It will be observed that there are no racks and pinions, screws, nor other mechanical contrivances for increasing the power. The amount of extending force required on a straight inflamed knee is never very great, and never beyond what the hands can readily exert by simply pulling firmly first upon one strap and then upon the other.

There is no ring or band surrounding the limb at the lower end of the instrument because such a thing is useless. The slot is kept in place by the band which passes through it, and cannot possibly get away. If it is desired to remove the apparatus for any purpose all that is necessary is to unbutton the two straps, when the brace can be slipped instantly off over the foot, and can be as easily re-applied. It is light, convenient, painless, and efficient.

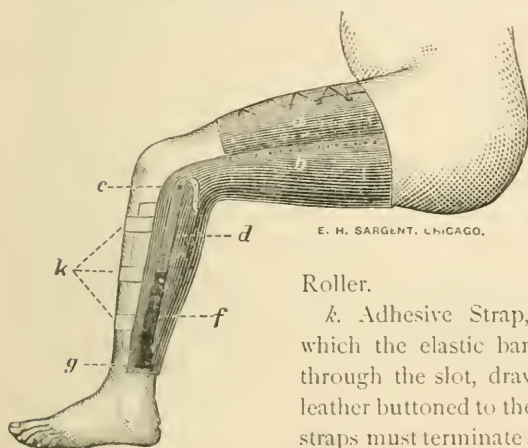
If, as often happens, the knee is not only inflamed, but also fixed in a bent position, most surgeons hold that it is necessary to straighten the knee before an apparatus can be worn. Now the straightening process itself is irritating, and tends to exasperate the inflammation. Dr. H. Davis devised an extension for bent knees, but it has not gotten into general use.

I have resorted with decided satisfaction to the following plan:

A plaster cast is first taken of the posterior half of the limb, from the nates to the heel. To this a thin splint *b*, of hammered brass, is fitted. The upper part is completed by the addition of leathers *a*, which lace in front, and by thus embracing the thigh and the lower portion of the

hip in its hollow frustum of a cone, makes a basis for counter-extension. A slot *g* is made in the brass on either side at the lower end, and provided as in the former apparatus with a slender friction roller on the upper border. Adhesive straps are applied in the same manner as before, terminating in elastic bands or doubled tapes, which pass down through the slots, and turning up across the rollers, button or tie to the knobs *c*. By some addition to its details, this apparatus can have a joint at the knee, and be made to gradually straighten the knee.

SPLINT FOR INFLAMED KNEE IN THE BENT POSITION.



- a.* Leather, laced in front.
- b.* Brass Splint, hammered to fit the limb.
- c.* A Knob.
- d.* Leather Strap.
- f.* Elastic Band.
- g.* Slot and Friction

Roller.

k. Adhesive Strap, to the lower end of which the elastic band is sewn, then passed through the slot, drawn strongly up, and its leather buttoned to the knob *c*. The adhesive straps must terminate somewhat above the slot.

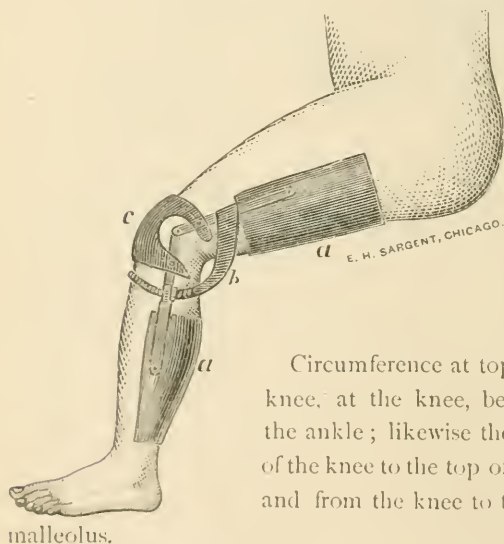
If there is nothing peculiar in the form of the limb, a common tinner can fit the splint to the patient without a plaster cast.

Where a splint is required purely for straightening knees which are fixed in a bent position, the following plan works admirably, and avoids the inconvenience of many of the splints now in use.

Many surgeons still rivet the thigh and leg pieces *a a* fast to the rods that pass to the joints at the knee, thus making each arm of the apparatus a rigid lever. The evil of this plan is that in spite of the knee cap *c*, when the extension force is applied the centre of the instrument draws back a little, and the entire pressure is made at the upper and lower ends near the hip and the ankle. Here the instrument digs painfully into the flesh, in spite of all precautions. To avoid this, the armor pieces *aa* should hang by their centres, as a cannon hangs on its trunnions, by movable joints, so that they always apply themselves painlessly to the surface of the limb, pressing equally in all parts. This part of the plan has been in use quite a number of years, and seems to have occurred

almost simultaneously to several surgeons, while it is still unaccountably neglected by others. Being an old device among mechanics, its invention cannot be specially credited to surgeons. The power required for the extension has usually been obtained either by a straight brace screw behind the knee, or by a small endless screw on either side. The straight brace screw has the inconvenience of being in the way when the patient desires to sit in a chair. The endless screw joint, often incorrectly called a "cam joint," is by far the neatest and most compact power that has been used, but it has the objection of being very expensive; and, moreover, as it is so close to the centre of motion, the pressure on the teeth of the semi-circle is immense, and not unfrequently breaks them.

INSTRUMENT FOR STRAIGHTENING BENT KNEES.



aa. Sheet Steel Pads, lined with chamois embracing posterior half of leg and thigh.

b. A Curved Screw, on which a nut turns, to make forced extension.

c. Knee Cap.

MEASUREMENTS REQUIRED.

Circumference at top of thigh, also above the knee, at the knee, below the knee, and above the ankle; likewise the distance from the centre of the knee to the top of the inner side of the thigh, and from the knee to the leg a little above the malleolus.

Expensiveness of apparatus is a serious objection for great numbers of the patients who need treatment; I have therefore sought to combine the economy of the screw with the convenience of the "cam joint." For this purpose I attach on each side a simple screw bent to a semi-circle. The screw is riveted firmly to the upper arm of the instrument, and runs through a perforated projection on the lower arm. A nut, turned by a key, furnishes the requisite power to force the limb to a straight position.

All the splints for treating *morbus coxarius* are modifications of the original idea of Dr. H. Davis. Most of them make extension by means

of a rack and pinion, which works well. Surgeons living in country districts, however, find it rather difficult to get them constructed by their home mechanics. They are deterred especially by the rack and pinion, which looks simple enough, but which is very difficult of construction to country locksmiths and gunsmiths. In such circumstances I have often advised the country surgeon to substitute a screw sliding in a tube for the ordinary extension bar, and the whole difficulty then disappears. The extension is regulated by the nut, which can be made hexagonal, and turned by a little wrench; but even this is not necessary. If the nut is made to work easily, the surgeon can seize the tube in one hand and the screw in the other, and easily make with his hands all the extension the patient will tolerate, while the thumb turns the nut down against the tube to hold the extension. The nut should have a little knob or tooth on its lower side to fit into a notch in the top of the tube, to prevent it turning spontaneously during the movements of the patient. The following cut shows the screw fitted to a splint somewhat like that of

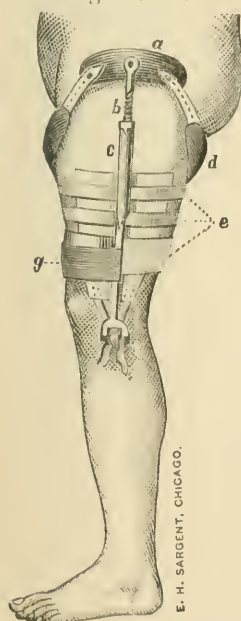
Sayre. The steel semi-circular band *g* goes half around the front of the limb, and on the opposite side has a short rod projecting down beside the knee to tie tapes to, like the one shown on the hither side in the cut.

EXPLANATION.

- a.* Top Pad, applied just below crest of ilium.
- b.* Screw, sliding in Tube *c* and regulated by a nut.
- d.* Perineal Band.
- g.* Half Band of Steel in front of thigh.
- e.* Adhesive Straps, fastened to lower end of instrument, both sides of the thigh, by tapes.

In certain cases it is desirable to use a long splint, coming down to the foot, and riveted into the heel of the shoe. In that case the adhesive straps are transferred to the leg, and the tapes tied to eyelets or knobs properly secured to the lower end of the rod or to the shoe. The modifications required are obvious and simple, and do not need an engraving to be understood.

The belt strap around the waist and the strap to buckle around the lower part of the thigh, insisted on by many surgeons, are utterly useless; the instrument assumes a better position without them. Its natural direction is decided by the line between the extremities of the perineal



band and the tapes on the adhesive straps; and this position should not be interfered with.

In all those cases requiring adhesive plaster extension, the surgeon will find the "rubber plaster" of Seabury & Johnson an immense improvement on the old varieties.

In joint diseases of the superior extremity a similar simplicity is attainable. I have under treatment at present a chronic inflammation of the wrist, with the following easily constructed apparatus. A rectangle of thin brass or tin is bent into the form of half a cylinder, long enough to extend from the elbow to the tips of the fingers. At each side of the elbow is a slot and friction roller. At the other end are two eye-holes in the end of the brass, half an inch in diameter. The hand, being enveloped in rubber, adhesive plaster, with tapes attached, is secured by tying the latter into the eye-holes. Other plasters on the forearm above the wrist have elastic bands attached to their upper extremities, terminating in thin leather straps. The latter pass over the friction rollers at the top of the instrument, turn downward, and are buttoned to knobs on either side. This makes perfect extension; and yet the apparatus can be easily made in the smallest country village.

If the elbow requires extension, either in a straight or bent position, the same principle is perfectly available, by merely varying the form of the tin case. The friction rollers so often referred to are the simplest possible things. They consist of simple pieces of strong wire soldered to the brace so as to cross the desired edge of the slot. A little cylinder of tin or sheet brass loosely surrounds the wire, so as to revolve freely when the elastic band is drawn over it.

These things are simple, easily made, easily managed, and cost a mere trifle. The whole complex system of screws, nuts, racks, pinions, and extension bars of every description, are in nine-tenths of the cases cumbrous abominations compared with the less complicated plans. I confess to having used them in former years, but at present I only employ them in a few peculiar cases.

In the matter of spinal supporters for Pott's disease, a great step has been gained in the direction of simplification by the plaster of Paris dressing. It enables country surgeons, however remote from instrument makers, to apply to a large portion of the cases perfectly efficient supporters without the aid of any mechanic. If, however, a more permanent apparatus is desired, any village surgeon can construct an efficient brace for Pott's disease, if he will give attention to it and personally supervise his gunsmith or locksmith whom he will need to enlist in the work.

There are only two principles of any real value in this class of apparatus. One is the splint principle, which, applying steel splints with proper pads along either side of the spine, seeks to lash the body firmly back to the splints. This is not merely an attempt mechanically to arrest the growth of the deformity; it is curative of the inflammation. Every vertebra rests on three surfaces of support, viz. : the body of the bone in front, and the two articular processes behind. The body of the bone is alone diseased, and its inflammation is perpetuated by the rocking and pressure of the other vertebræ upon it. The articular processes are perfectly healthy in most cases. Now by flexing the spine well back against the splint, the pressure is brought upon the healthy articular processes, and taken off from the bodies of the vertebræ, which, being thus relieved, get well spontaneously.

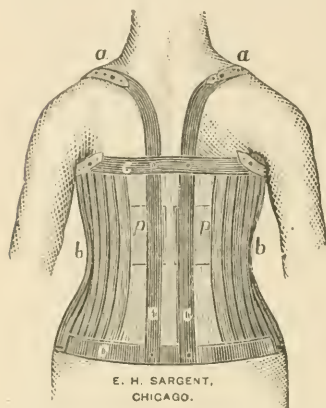
The other principle is that of the corset. Dr. Wood, of Boston, formerly made very efficient supporters, which were in principle nothing else but corsets. The corset principle is best adapted to the adult female form. Here the wide spread of the hips makes a rapidly sloping frustum of a cone, on which rests the inverted frustum formed by the chest, the junction of the two being at the smallest part of the waist. If a well-fitted corset, full of whalebone, be applied, and be made so as to lace in front, instead of using the ordinary steel locks, the action is as follows: The inverted cone of the waist rests in the hollow cone of the upper half of the corset. Now by drawing upon the strings at the lower cone, the corset tends to rise on the slope of the hips and to push up the cone of the chest with it. Hence the corset principle is a valuable auxillary in adult female cases, and to a less extent in males also. In young children there is no contraction at the waist, and a corset acts only as a splint.

Now the country surgeon, by the help of a mechanic and any sewing woman, may easily combine both these principles in one instrument, as shown below. The corset should lace and not lock in front. The drilling of which it is composed must be gored to fit the waist accurately, and it should be filled as full of whalebone as it will hold.

The old obsolete plan of trying to lift the upper part of the body by means of extensible crutch pieces running up to the axilla, is now abandoned by all surgeons, because the axillary plexus of nerves does not tolerate any steady pressure.

The instrument makers of our large cities deserve severe censure for their folly in two things. First, their obstinate adherence to and trust in these useless sub-axillary crutch pieces; and second, the unprincipled way in which they take orders for spinal supporters

to be made from mere measures sent by distant patients, without their personal presence. A spinal support made without the personal presence of the patient is almost invariably a failure; yet many thousands of dollars are thus annually swindled out of patients illy able to lose it.



a a. Shoulder Straps.

b b. Corset, lacing in front, and well filled with whalebone.

c c c c. Steel Framework.

p p. Pads, pressing on each side of the projection of the vertebræ.

If the patient cannot go to some surgeon of repute in a town or city, he should by all means get his home physician to construct a plain supporter on sensible principles, by the help of the village locksmith. He may depend upon it, that

although the work may lack elegance in its appearance, it will be infinitely more useful to him than a brace made by a distant manufacturer from mere measure, no matter how celebrated that distant and unprincipled manufacturer may be.

No. 6 SIXTEENTH STREET, CHICAGO, ILL.

DISLOCATION FORWARDS OF THE LOWER END OF THE ULNA.

BY

ROBERT F. WEIR, M. D.,

Surgeon to the Roosevelt and New York Hospitals.

The rarity of dislocation forwards of the lower end of the ulna will be appreciated by the fact that the exhaustive works of Malgaigne and Hamilton give a total of but ten cases on record. Of this number nine are alluded to by the former author, and one by the latter. The fact brought out by a consideration of these cases and from the one now presented is that the violence was brought to bear upon the lower part of the ulna when supination was strongly marked. Thus Boyer reported that in his case the injury was caused by a man who, in endeavoring to eject a woman from his room, seized her roughly by the wrist when the forearm was strongly supinated. The two cases of Malle resulted from falling on the forearm when it was in a similar position. Dupuytren, who also met with such a

case, (or rather two, as the one reported by Malgaigne occurred in Dupuytren's wards,) stated that it was produced, as was also Malgaigne's, by trying to ward off a falling embankment. The remaining cases were met with in the practice of the following surgeons: Godelier, Valleteau, Espiaud, Parker and Desault; the latter, however, encountered it in the cadaver, and from him we learn that the lesion had caused marked interference with flexion and extension of the wrist.

As to the reduction of the dislocation, though the seizure of the shaft of the radius by one hand, and the shaft of the ulna by the other hand was resorted to by several, who then attempted to move the bones towards each other while pulling them apart laterally, yet the best success has been obtained by direct pressure upon the dislocated head of the ulna, forcing it thus into its place.

CASE—Mrs. D., a widow, 48 years of age, rather stout in habit, was seen by me February 9th of the present year. She had a few minutes previous to my arrival been calling down the dumb waiter closet to her man below, when he, misunderstanding her commands, suddenly drew down the dumb waiter, so that her right hand and lower portion of the forearm were forcibly supinated and pressed down by the descending shelf, while the posterior surface of the forearm rested fixed on the ledge of the opening into the closet. The wrist presented a most singular deformity; it was much narrower than the other one, and in place of the prominence usually given to the lower third of the ulna, there existed a deep groove nearly two inches long, and the head of the ulna had disappeared from its normal locality, and was found projecting very slightly on the palmar aspect of the joint, much nearer to the median line. The hand was held in a semiflexed position, and nearly completely supinated; and from the great pain but little motion could be imparted to the joint. A dislocation forward of the ulna was recognized, and an attempt was made without an anæsthetic to reduce it by extension and pressure of the ulna towards its proper place. This was so painful that ether was administered, and then very slight direct force upon the head of the ulna was sufficient to crowd back the dislocated bone into its original locality. Before this was accomplished, it was noticed that flexion was much hampered, and pronation also much limited. No fracture was to be found, and after the reduction the motions of the joint were perfectly restored. Considerable swelling ensued, lasting several days, but at the end of ten days the wrist had nearly resumed its freedom of motion. This restoration of function has since been completed, as has been shown in a recent examination of the patient.

TREATMENT OF BOILS BY SULPHIDE OF CALCIUM.

BY
T. CURTIS SMITH, M. D.,
Middleport, Ohio.

R. S. W., æt. 24, lawyer, nervous temperament, of general good health, spare habit, industrious, temperate, costive habit, came to me complaining of a large boil on his right thigh, with the statement that he "had not been clear of boils for several months; as soon as one commenced to recede or suppurate, one or more new ones would commence to make their appearance, and every large boil is encircled with a crop of small ones." He thought that each one would be the last, but had now become discouraged in waiting for the last one to leave him. As he was in average health in all other respects, I at once prescribed sulphide of calcium, grs. iii. every three hours. The boil now on his thigh was about three and a half inches in circumference at its base, very painful, and throbbing at every pulsation. The boils preceding this one had been very slow in development, and suppurated but little.

On the second day after commencing the treatment the boil softened at its point, and on the third day discharged pus profusely. A boil that had commenced in another locality began on the second day to disappear, and soon no appearance of it could be discovered. The large suppurating boil was not encircled by a crop of small ones, as had been all its predecessors. From that day to this (18 months) he has not been troubled with any furunculous eruption.

CASE 2.—Mrs. S., æt. 68, of nervo-bilious temperament, while recovering from a long attack of serious nervous disease, became afflicted with successive crops of boils. They appeared on the neck, shoulders, arms and thighs, and being often located in such a manner that she could not lie in any position without great discomfort. Like the former case, as soon as one crop commenced to recede a new crop would appear, and none of them suppurated more than a few drops of bloody pus; some none at all. The general tonic course she was on was continued, and the sulphide of calcium, grs. iii. given every two to three hours.

By the next day the boils were less painful. The large ones, several in number, commenced to discharge pus very freely on the second day of this treatment, and rapidly disappeared. Several small ones, the size of a hazel nut to that of a small chestnut, commenced to wilt on the second day of the treatment, and in four to five days nothing was left to mark their former existence except a purple spot. No new crop of furuncles followed, and her gain in general health was much more rapid

than while annoyed by the boils. This case I treated in February, 1875.

Mr. B., a steanboat captain, a large, portly man, sanguineous temperament, came to me a short time since with a very large boil on the anterior face of the right thigh, stating that he had not been entirely clear of a large boil in some locality for six months; that he had tried various remedies without effect in preventing new ones from coming out. His general health was excellent, and nothing discoverable at fault except these boils. He was ordered sulphide of calcium, grs. v, every three to four hours.

Three days later he reported that the boil was becoming soft and would soon burst. He also stated that this one had advanced more in the last three days towards maturation than any of the former boils had in two weeks. In this case, as in the others, the boils had discharged nothing but a few drops of bloody pus, were very slow in developing, and also in the retrograde process; one boil sometimes continuing for four to five weeks. The one now on hand suppurated very freely on the fifth night, after which it rapidly disappeared. No new ones put in an appearance. No disturbance of the general health or appetite was at any time noticed while taking this agent; on the contrary, patients have generally spoken of feeling better while taking it than before commencing its use.

My friend, Dr. E. C. Fisher, at my suggestion put a case of slow hard "blood boils" on this remedy, several of which existed on the face, were hard, red, oval tumors, with no sign of suppuration in them. In three to four days they showed signs of softening and of commencing absorption. In a very few days more they disappeared without suppuration.

I have found this agent equally beneficial in the slow form of scrofulous abscess, shortening the time of its existence very materially. It has also done me very good service in cases of infantile eczema, and some chronic scaly skin diseases. As this is purely a clinical paper, I will not offer here any theory as to its mode of action.

RECTO & VESICO-VAGINAL FISTULA—REMARKABLE RECOVERY.

BY

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The case which I desire to present may be epitomized thus: extensive laceration in a primipara, resulting in rectal and vesical fistula; operation on second day; sutures all failed; absolute incontinence of urine, and no control over the alvine evacuations; experts gave no encouragement

for the future; perfect recovery and restoration of functions induced by very frequent ablutions with carbolic acid in water, and constant dressings of carbolic acid in oil; subsequent pregnancy and parturition, without accident. This epitome so thoroughly presents the main features of the case, that I am somewhat tempted to omit the full record, and pass immediately to comments and reflections; at any rate I may spare myself and the reader all reference to minute details.

Mrs. R., age 20, perfect specimen of physical excellence, primipara, at full term, had not suffered any of the ordinary inconveniences of pregnancy.

The first indication of approaching labor was a rupture of the membranes and a free draining off of the liq. amnii for more than two days before she had any pain. At the end of another day labor had advanced sufficiently to show a breech presentation—child living, and condition of mother good. Through the next twenty-four hours labor active and progressing regularly, but slowly. Patient had obtained some rest by the occasional inhalation of chloroform, during which the contractions were regular and strong, and the dilatation of the os apparently promoted.

Forty-eight hours had now passed since expulsive pains began, and slight symptoms of exhaustion began to manifest themselves. Dr. Skene was called in consultation, and advised non-interference. Labor continued through next twenty-four hours, with some advance of the breech, and full dilatation. Pains were now less and less efficient, and upon consultation with Dr. Skene it was decided that delivery could not be completed without artificial aid. By means of the blunt hook, and ultimately by forceps to the head, the child was born alive, but died on the third day from imperforate intestine, the imperforate condition extending high into the alimentary canal, as evinced by the fact that no urine was secreted during the three days of its life.

Upon careful examination of the mother, it was found that the urethra was badly torn, and the sphincter entirely divided. During the next forty-eight hours the bladder was emptied by the catheter, which was introduced through a confused and swollen mass. From this time the incontinence was complete.

Five deep silver-wire sutures were made in the perineum by Dr. Skene, at my request, on the second day. These were removed on the tenth day, when to our great disgust it was evident that no improvement whatever had taken place. A dressing of carbolic acid and olive oil had been constantly used, with such ablutions as were consistent with suitable rest of the parts.

After the stitches were removed my patient was examined by Prof. A. J. C. Skene, and also by Dr. Alexander Hutchinson, and from neither of these gentlemen of large experience could I get any encouragement that either with or without operation, my patient would now be ought else than an object of commiseration. Her vagina was almost constantly occupied by a mixture of feces and urine. I procured some fine oakum, and kept the parts gently packed with this, saturated with a mixture of carbolic acid (liquified crystals) and glycerine, each one drachm, and olive oil one pint. This was renewed as often, day and night, as seemed to be necessary, either for comfort or cleanliness; and whenever the change was made a lotion of carbolic acid and glycerine, of each one drachm, to warm water one pint, was faithfully used with a sponge, till the parts were as thoroughly cleansed as possible, and then the carbolated oil dressing was immediately reapplied. At the time of my daily visit I performed this ablution myself, in order to note the progress of the case, and also to instruct the nurse exactly how to proceed in my absence.

This patient was not restricted as to position, any more than one would be after the operation of lithotomy. The same ablutions which were used to keep the lacerated tissues in a healthy granulating condition were also necessary to preserve the integuments about the hips, so constantly were they subjected to irritation by the excreta.

What remains of this case can be expressed in very few words. The healing progressed uniformly, so that at the end of six weeks perfect control was regained over both the bladder and the rectum. I do not think this result could have been attained by any less vigilant course of treatment, and I attribute much to the faithfulness of the nurse in the performance of a duty which was very exacting by night and by day. Another point which I desire to emphasize is the use of carbolic acid in this case. I attribute to it an influence which I do not remember to have seen specially referred to—I allude to its immediate oxidizing effect upon granulating surfaces. If a film of carbolic acid be poured upon a coagulum of venous blood, a bright pink instantly takes the place of its dark hue. The constantly refreshing influence of this principle I believe had much to do in disposing these tissues to heal.

It is now two years since this disastrous parturition occurred, and the strength of the cicatricial tissue has lately been put to a severe test. Eight weeks ago the second labor was accomplished in about four hours from its inception. Child, a female; weight, ten pounds. A few fibres were rent, but no unpleasant symptoms were experienced. Mother and child are now perfectly well.

TRANSLATIONS.

DRESSINGS FOR WOUNDS.

A series of five Clinical Lectures delivered at the Charity Hospital, Paris.

BY

L. GOSSELIN, M. D., Etc.

Professor of Surgery in the Faculty of Medicine of Paris, Etc.

Translated from "*La France Médicale*" for the ARCHIVES OF CLINICAL SURGERY,

BY

BARNARD ELLIS, M. D.

GENTLEMEN—We are called every day to apply dressings to wounds and sores for the purpose of producing cicatrization, and I believe it to be not unprofitable to bring before you from time to time the end we wish to attain, and the processes by which we arrive at our results. In my estimation, then, it will be well for your instruction to inaugurate the series of clinical lectures which I am bound to give you this year by the study of the different modes of dressing wounds, or, to speak better, by the study of the physiological end which we propose to ourselves each time we apply a dressing to a wound. In a majority of cases the kind of dressing is of little importance, in the proper meaning of the word, as one dressing will succeed as well as another.

At all times, in reality, when we have to do with a wound, the first general indication, and which overshadows all others, is to cover it, and keep from it all exterior agents. Now, oftenest the mode of protection is unimportant. As for instance, in case of a wound made by a pointed instrument, or a very superficial wound made by a sharp-cutting instrument, the dressing or protection simply favors the natural tendency of all wounds of this nature—that is, to immediate cicatrization. Yet it is well to remark, that before applying the dressing we must suspect the possible presence of foreign bodies, of which some are visible and easily removed—such as bits of linen, clothing, etc.—and of others not visible, not palpable, and which necessitate repeated washings, and perhaps suction with the mouth or by the cupping glass. I shall speak afterwards of those infinitely small microscopic agents so often communicated by operating knives, as for instance, and to us a familiar example, the prick by a dissecting knife. These precautions once taken, the mode of dressing, I repeat, is indifferent.

Unhappily, wounds do not always present this benign character; they are often very extensive. They are no longer simple solutions of

continuity, but losses of substance, long and deep, reaching often to the aponeuroses, which in many cases they do not respect. The surgeon must then look for a dressing which will respond to one of the three following objectives, viz.: to favor either immediate cicatrization, or cicatrization after suppuration, or, as well, intermediary cicatrization.

Before deciding upon the first of these indications, we must be sure that the condition of the wound, is such as to favor healing by the first intention. * * * * The edges must be clean, without violent contusions, free from all foreign bodies, blood clots, &c., and juxtaposition of analagous tissues made as far as is possible: that is, skin to skin, muscle to muscle, &c.,

We then see exuding from all parts of the wound, in its depths as well as upon its lips, following a moderate irritation, which Hunter called adhesive inflammation, a transparent, roseate liquid of a syrupy consistence. This is plastic lymph, which Thomson, however, called *coagulable* or *organizable* lymph, a fibrino-albuminous substance, of which the fluid parts are re-absorbed, which after twenty-four hours becomes filled with newly formed vessels, and which becoming more and more vascularized and organized, is destined to become the cicatrix.

I shall occupy no more time on this point. I hold nevertheless that this exaggerated transudation of plasma is not sufficient to provoke complete immediate reunion. Certain modifications must intervene, and these interventions are accomplished at the expense of the cellular elements. These cellular elements, these corpuscles of the conjunctive tissue, multiply themselves by division, and this process commenced in the case before us in less than an hour. It established a sort of current from the capillaries to the cells, and from the cells to the capillaries. These cells, separating themselves, send out mutually prolongations, and are endowed with a very appreciable individual locomotion.

Recklinghausen has, however, explained these curious phenomena perfectly. This segmentation of cellular elements coincides exactly with the resorption of one pint of this plastic lymph, of this organizable lymph that I have already spoken of, and soon comes the moment when the juxtaposed surfaces are formed only of cells, re-united by a weak quantity of gelatinous tissue, which becomes solidified little by little.

I have used the term adhesive inflammation. We are always disposed to admit this inflammatory process in surgery, so rare is perfect immediate reunion.

There is always one point which suppurates, a point limited as possible, but which, in spite of all our care, does exist, and we have a *sort of*

mixed reunion, which we must carefully guard ourselves from confounding with *intermediary cicatrization*, a term which I reserve for further explanation as an entirely different variety. To favor the evolution of these phenomena certain processes are used.

First, I ought to say to you that immobility is the essential condition precedent to healing by the first intention; and, strictly speaking, it alone is sufficient where the sides of the wound are in contact. This repose of the parts is assured by the various means used in bringing about this contact.

The position is equally of extreme importance, and it is a general precept in the subject matter, and one from which we should never allow ourselves to deviate, that the parts be always placed in an unconstrained position. To this precept there is no exception. There was a time when bandages were used to retain the lips of wounds in place, but before long it was found that they were treacherous, heavy, difficult to apply, and badly supported by the patient, and a great advantage was found in replacing them by more simple means—sutures and agglutinants. Thus, then, you will find it well to employ the different modes of suture, the spring forceps, the use of which Vidal popularized, and all the series of agglomeratives, from the strips of dyachylon plaster to the little bands of cloth dipped in callodion.

But, gentlemen, there are many superficial wounds where it would be illusory to hope for cicatrization by first intention. Without counting ulcerous wounds, all those produced by blunt instruments, and which have become complicated by attrition or mortification of the integuments, gun-shot wounds, for example, are fatally given to suppuration. Aside from these wounds, there are others also, which, without presenting the same characters, suppurate nevertheless.

Now, we should ask ourselves what is the proper dressing in these different cases. But before entering upon this study, in view of this variety of wounds, I wish to call your attention to the fact that there are three periods which must be held in careful account. They are: *First*, the period of modification or inflammation; *second*, the period of suppuration, with formation of a special or pyogenic membrane; and third, the period of desiccation of this same membrane.

In surgery we cannot occupy ourselves too much with the first of these periods, which is called also the *period of preparation* for suppuration, the inflammatory period, because the phenomena of modification—the expulsion of the mortified parts—are always accompanied with local symptoms: redness, swelling, heat, and sometimes fever, with a train of

more or less formidable general symptoms. In these cases we must watch attentively the progress of the general symptoms ; but for the moment we return to the subject of dressings—those dressings which offer the most advantages. And it is to those dressings which best protect and at the same time moderate the inflammatory processes, or, at all events, do not excite them, that we must turn ; and in this antiphlogistic treatment we have simple cerate, cold cream, glycerine, cataplasms, water dressings, and incubation.

Cataplasms may be applied warm or cold.

Water may be applied at various temperatures, and in various ways ; from 59° to 68° F., and by imbibition, irrigation, and immersion.

Imbibition consists in covering the wound with wet cloths, covered with India rubber cloth, to prevent cold and avoid evaporation.

Irrigation consists in pouring a uniform current of liquid upon the surface of the tissues. Many apparatuses have been invented for this, but the best is that of my colleague, Mr. H. Larrey, which consists of, first, a vase, placed above the injured spot ; second, any vessel to receive the liquid after it has bathed the wound ; and third, of a syphon of glass or tin, which conveys the liquid from the vase to the wound. Often a simple band of cotton cloth fixed in the vase answers well.

Immersion is simply a local or general bath, and I have not been able to get so good results as have been claimed for it.

Incubation has fallen into oblivion. J. Guyot, in 1840, imagined that to submit the wounds to a prolonged action of heated air, say from 86° to 104° F., was beneficial. Lately, in 1870, Dr. Leon Le Fort proposed a mode of dressing by a continued bath, which consisted of several compresses wet with alcoholized water, and hermetically sealed with waxed cloths covering all the neighboring parts of the member. Liquid alcoholic evaporation in this case cannot take place, and the dressing becomes a sort of continued bath.

Such are, in a few words, gentlemen, the antiphlogistic methods which render such great service during the period of modification of wounds which will eventually suppurate.

We come now to the second period. It is the pyogenic membrane which brings about cicatrization, and you will find in your text books what this membrane is, and what are its characters. * * * * It is by the drying up or retraction of this pyogenic membrane, this new granulous tissue with which the wound is covered, that cicatrization comes ; and this state constitutes the third period, which is confounded with the second in a point of view of dressing by choice of all the modes, which

second period is characterized by three great phenomena; viz.: first, the progressive retrogression from the periphery to the centre of the pyogenic membrane; second, the diminution of purulent secretion; and third, the complete desiccation of this membrane, which partakes the characters of fibro-cellular or cicatricial tissue. Thus reparation of loss of substance is found, and this repair differs from immediate union in this, that this new membrane supplies the demand consequent upon the absence of immediate reparation of damage done.

Now when these two periods are passed regularly, without complications, nothing intervening to embarrass the progress of the phenomena which I have briefly described to you, I would say voluntarily that the mode of dressing is indifferent, as in these cases all our dressings are good, provided they fulfill the two special indications of not giving pain and not bringing contagious substances upon the wound. This second indication is easily fulfilled in our private practice where our patients are by themselves and in good hygienic conditions, but it is an entirely different matter in our hospital practice, where our patients are in close neighborhood where there is agglomeration of disease. This fact is unhappily too well demonstrated today, although we have no unexceptionable and positive proofs upon which we can rely. It is, perhaps, going too far to say that in our hospital wards all the linen, the strips of cloth, the material for dressings, are full of miasms; that the lint is impregnated with deleterious substances; still it is wise and good surgical practice to suspect this contagion, and to act as if it existed in fact. Then, when one of those terrible epochs (which are unhappily too frequent) come to us in the great hospital centres, those fearful complications of erysipelas, hospital gangrene, purulent infection, etc., we must redouble our vigilance, and be careful not to allow dressings to be carried from one patient to another. I repeat, that those two conditions fulfilled—first, giving no pain, and secondly, conveying no contagious substances upon the wound—all modes of dressing seem to me to be alike; and if you will consult the old pharmacopœias you will be utterly surprised and astonished at the innumerable quantity of topical dressings described there, which proves superabundantly that suppurating sores, when the hygienic conditions are good and favorable, heal under no matter what dressing or salve may be used.

But besides these cases of normal progress, so to speak, we have those where particular dressings are necessary. These are found particularly in hospitals. We often meet wounds which become irregular under special influences; the granulations become carneous and bristling,

standing out each one by itself, of a feeble and pale color, the pus becoming by loss of its consistence, serous fluid, and the general appearance of the sore is wan and pale. It is at this point that the work of reparation ceases. The question now is how to remedy these accidents, and the dressing should be so modified as to return to this anæmic, atonic, sore, life and force, that the work of cicatrization may proceed to full repair. General treatment and change of hygiene will do much, * * * * but we are now occupied with the subject of dressings. In these cases of atony success is often found in the use of aromatic wine, in styrax ointment, which irritates the sore, excites and animates vascularization and secretion of pus. So also basilicon ointment, but little used now a days, and a solution of sulphate of zinc, 200 parts to 1.

We have phenomena of still another kind. Ecchymoses, sometimes disseminated, sometimes united in groups, appear on the surfaces of the wound. Little ulcerations may appear, or, perhaps, this granulous membrane has a whitish coating, which Robert called the diphtheritis of wounds. This is generally dissipated by cauterization with nitrate of silver, or with lemon juice.

In other cases we have hospital putrefaction, which I shall define by three words, diphtheritis, ulceration, and gangrene; against which pulverized camphor and particularly cauterization by the red hot iron succeeds.

Now, gentlemen, as these two last periods may present either one of these irregularities, as I shall explain to you, I have not separated them in the study of the dressings which ought to be used. Besides these superficial sores, there are others with a larger surface, which may cicatrise without the mechanism of immediate union, or union by the first intention, without there being more suppuration. These sores follow an intermediary course. The edges show but slight swelling, they do not become too red, and the inflammation does not spread.

These borders furnish sanguinolent serum. Then, when this state has persisted for four, five, or six days, when we believe it is going to cease, to give place to other phenomena, that we are nearly ready to give it new attention, we are astonished to see the symptoms persist, without there being any trace of a pyogenic membrane, or of suppuration. During eight or ten days this serum presents itself with the same characters as at the beginning; then soon the place becomes dry, and a new tissue is formed, through which reparation is effected. This tissue is formed more slowly than in the case of union by first intention, and more quickly than in the case of union by second intention; quicker

than in wounds of the head dressed in a certain way, with alcohol, for example, and I attach very high importance to this particular ulceration, which I have studied with great care. This is what Dr. Jules Guérin brought to notice in speaking of immediate organization, which is generally effected under the skin, a work analagous to that which presides over reunion of fibrous or of osseous tissues. Now the processes which go on under skin which has not been implicated, may also go on upon certain dressed superficial sores, with the aid of certain processes. I insist upon this point, gentlemen, for I shall recall it soon to demonstrate to you that in the cicatrization of deep wounds it is necessary that immediate organization intervenes.

I have said enough upon the subject of superficial wounds. I must now approach the study of the dressings which ought to be applied to wounds of another variety, and much more important than the preceding ones described. I intend to speak of deep wounds. It would be easy to make a multitude of divisions, but first, before and above all, we will consider the deep wounds which implicate the bony structures. This deserves our particular attention, because, in a certain measure, the mode of dressing will prevent the development, or, at least, retard the progress of those terrible accidents which too frequently complicate, alas, these deep wounds, and so seriously menace the life of the patient.

What then are these dangers so grave? I do not wish to study them in detail; I only recall them to your attention. First, we have the traumatic fever, which may intervene in the first period of healing, which fever will produce almost fatal suppuration if left to itself, which fever Richerand says is the inseparable companion of all wounds having a certain extension and curable by suppuration; and which fever Dupuytren believed had for its end and aim simply the preparation for cure, and of which the presence as well as the intensity depends upon the number of tissues involved, and the variable forms in which they are found, according to their nature and their mutual dependence one upon the other. Secondly, there is prevalent infection when the pyogenic membrane is formed. Now the question is how far can the dressing modify this tendency to aggravation. But to answer clearly and precisely such a question it is well to establish certain distinctions among these deep wounds which implicate the bone.

First, we have wounds of the skin which are narrow, for example, in case of compound fracture.

Secondly, we have wounds where the skin has disappeared upon a large surface; for example, amputation of the thigh.

In the first case, the dressing should have for its principal indication, its first objective, by all the means at our command, immediate cicatrization of the integument. To this end we must put the deep parts in such conditions that they may repair themselves, after the mechanism indicated by Guérin, that is, by *immediate organization*. And when we think of it, gentlemen, it is altogether curious, and instructive at the same time, to see how difficult it has been to establish this surgical fact, this indication nevertheless so simple, and what obstacles it has had to surmount before it was able to conquer, so to speak, its freedom. For a long time we were occupied with a single idea, viz : to calm by the aid of emollient topical dressings the inflammation of the edges of the wound, without thinking of the possibility of reuniting these edges in the end to suppress suppuration, and thus remove from the wound the possibility of those grave complications which prevent cicatrization. Dr. Chassaignac was the first who called attention to this point. In 1844, in the seance of the 11th of November, he showed before the Academy of Sciences that for three years he had put in practice in his hospital service a mode of dressing which he called *dressing by occlusion*. He covered the place with an immovable diachylon plaster in imbricated strips. The pus was allowed to escape through the fenestrated linen bandage, coated with simple cerate, the whole covered with lint. At the same date, Langier employed for the identical purpose gold-beaters skin, covered with a thick solution of gum Arabic. He attributed to this dressing a special property. He believed that the dried pus and blood formed a crust or scab, under which cicatrization took place. Imbricated bands of collodionated cloth fulfill the same indication, for in this the whole object is to maintain contact of the edges, favor cicatrization by excluding the air, and so facilitate the development of immediate organization.

But that which succeeds in this kind of wound will, without doubt, fail where there is large loss of substance, in those yawning wounds with osseous centres, such as are seen after capital amputations. These wounds, if left to themselves, are fatally prone to suppuration. The blood which bathes its surface will undergo putrid transformation ; gangrene will strike it in certain points, and we shall pass through all the series of the accidents of mortification. But you can easily understand that this surface constituted of elements so different, of tissues so dissimilar must undergo a profound modification before the pyogenic membrane can normally establish itself. And all this *ensemble* of pathological phenomena fails not to bring with it a train of general symptoms, upon

the gravity of which there is no illusion today for any person.

Now, gentlemen, the exact question is to combine our dressings so as to efficaciously intervene in this struggle between reparation and mortification of the tissues, and so to make our combinations as to secure victory to the work of reparation.

We now know very well what this formal, clear, and categorical indication is, and are no longer embarrassed, as we used to be, to formulate it. But this is not to say that we may be under the shadow of hesitations and gropings in the dark, but to show to you, gentlemen, that all the dressings proposed, while they may give good results, are each liable to be followed by failure.

At the bottom of all this is a truth which I wish to bring clearly to your minds: it is that all the dressings which have been eulogized within the last few years have had their times of brilliant success; all have also failed under certain conditions which it is impossible for us to appreciate. It is therefore wise to guard ourselves against the infatuation which accompanies innovations of all sorts, while it would be equally unjust to ostracise such or such a dressing, simply because its use is not constantly crowned with success. * * * * We are then to carefully study for ourselves, * * * * and to form a sound and serious opinion upon this question, a question of the gravest importance, since the lives of our patients are intimately interested.

For the sake of clearness in the explanation of facts, I shall divide the numerous modes of dressings into seven groups.

(To be continued.)

PROGRESS OF SURGERY.

REPORT ON THE SURGICAL DISEASES OF WOMEN.

BY

FRANK P. FOSTER, M. D.

On the Treatment of Rupture of the Perineum.—(Dr. G. G. Bantock, *Obs. Jour. Great Britain and Ireland*, Jan., 1877, p. 665.) Bantock excludes from consideration those superficial lacerations which involve only the skin or mucous membrane, *as far as* the perineal body. He argues in favor of immediate operation, opposing the attempt to secure union by merely keeping up apposition of the lower limbs, since this, although it keeps the lacerated surfaces in contact, at the same time closes the vaginal outlet, so that the lochial discharge finds its way out as best it can, *i. e.*, as much between the raw surfaces as *per viam naturalem*. In his own experience he has never known the immediate operation to fail, or the contrary method to succeed. Simple deep sutures should be applied, with as much care and skill as in the remote operation.

In the remote operation he discards the quilled suture, as causing projection and semi-strangulation of the perineum, and uses deep sutures of silkworm gut. First, however, if the laceration extends into the rectum, after completing the denudation, the rectal mucous membrane is brought together with fine sutures of Lister's catgut, which are left hanging out from the now restored anus. Like Thomas, he introduces the deep sutures in such manner that, after they are all inserted but not tied, no part of them is visible in the wound. They therefore include the whole depth of the wound. The bleeding having ceased, and the wound having been cleansed of coagula, the nates are allowed to approach, and the knees brought together. The sutures are then collected and held tight, while the tissues are pressed down upon the septum, so as to secure perfect coaptation by pressure from outside, but *not between* the sutures. The latter are then held firm by an assistant, and successively tied, beginning with the one next the anus. With these precautions, inversion of the skin seldom renders superficial sutures necessary. Bilateral division of the sphincter ani and semilunar incisions through the skin are unnecessary.

Urinary Fistulæ, [Zur Casuistik, Therapie, und Etiologie der Urinfisteln des Weibes,] (Dr. A. Hempel, *Archiv für Gynäkologie*, X Bd., 3 Hft.,

1876, p. 479.)—Hempel reports sixty cases occurring at Spiegelberg's clinic. Spiegelberg has no distinctive method of his own, but endeavors to adopt the advantageous features of various methods. His results were as follows:—Nineteen simple vesico-vaginal fistulæ were perfectly cured; one by cauterization, twelve by one operation, three by two, one by three, and two by four. Of sixteen complicated vesico-vaginal fistulæ, eleven were perfectly cured: three by one operation, three by two, three by three, and two by four; two were improved; two patients declined further operation, and one was still under treatment. Of eight superficial vesico-utero-vaginal fistulæ, six were perfectly cured; one by cauterization, two by one operation, one by two, one by three, and one by five; one patient declined further treatment, and one died. Of eight deep vesico-utero-vaginal fistulæ, six were entirely cured; three after one operation, one after two, one after three, and one after seven; and two patients left the institution before a new operation could be undertaken. Seven vesico-uterine fistulæ were perfectly cured; two by cauterization, one after one operation and cauterization, three after one operation, and one after four; two uretero vaginal fistulæ still remained under treatment.

On Vesico-Vaginal Fistula, (Dr. Nathan Bozeman), *The Lancet*, Nov. 4, 1876, p. 633.—Dr. Bozeman reviews the points of his own method of operating, which he calls "autoplasty by gradual approaches." He deprecates kolpokleisis, or obliteration of the vagina, stating that, in the five per cent. of cases in which it seems to be called for, little or no permanent good can result from the expedient, however successfully accomplished. After discussing some of the alleged disadvantages of his method of treatment, the author seeks to account for the lukewarm character of the support at present given by many surgeons to the suture operation, by their lack of success with it, due, as he thinks, to inattention to other morbid conditions of the vagina than the fistula itself, to the preparation of too broad or flat surfaces in paring the edges, and to the adoption of the dorsal or lateral position of the patient. He gives renewed expression to his decided preference for the button suture, regarding it as surer than any other form of suture to prevent reopening of the wound by recontraction of the dilated vagina during the healing process.

On the Method of Operating for Vesico-Vaginal Fistula, being a Comparison of Bozeman's Operation with that of the Author, (By the late Prof. Simon of Heidelberg), *Obstet. Jour. Great Britain and Ireland*, Oct., Nov., Dec., 1876, pp. 435, 497, 589, from *Wiener Meds. Wochenscler.*—Simon

thus rapidly sketches the essential differences between the two methods of operating: "While I operate on the patients in the supine position, with the buttocks much raised (an exaggerated lithotomy position), Bozeman makes use of the knee-elbow position, in which he fastens the patient. While I endeavor to draw forwards the parts bordering on the fistula, whenever this can be attained, Bozeman performs the operation while the parts remain in situ. While Bozeman pares the edges for the most part with scissors, I operate almost exclusively with the knife. While Bozeman employs a very complicated wire suture, I use a simple knotted suture of silk thread. And while Bozeman, in the after treatment, keeps a catheter permanently in place, and often gives large doses of opium, I enjoin no measure of precaution whatever, but allow the urine to be passed at pleasure, and permit the patient to leave her bed even on the second or third day if she pleases. Even in cases in which a preparatory treatment is necessary in order to render the fistula accessible to the instruments with which the operation is to be performed, I make choice almost exclusively of a rapid preparation, immediately before the operation, while Bozeman, in all these cases, prefers the gradual preparation."

He then gives the details of four cases operated on by himself, and three by Bozeman. In one of the former death occurred from suppurative pyelitis, with impaction of a calculus in one ureter. This condition existed before the operation, and the case is set aside, as Bozeman admitted that death would have followed either operation.

Of the three cases of each category remaining for comparison, Simon's results were: In the first case a small fistula, about as large as a pea, or one-twenty-fifth part of the wound, remained open; in the second, eventual complete cure, a small remaining aperture closing spontaneously; in the third, complete closure, except a small portion which lay beyond the sutures. Bozeman attained a complete cure in his first case; in his second, the whole fistula reopened, and the patient became incurable; and in the third, about four-fifths of the line of approximation were closed. The author therefore claims that his results were both absolutely and relatively better than those of Bozeman.

The particular impediments to success in each of the six cases are then discussed, and may be summarized thus:—In all of Simon's cases the urethra was implicated. In only one case, Bozeman's third, was there very great difficulty on account of the inaccessibility of the fistula, and this difficulty was overcome. In one of Simon's cases the fistula was of unusual size, involving the whole vesico-vaginal septum. Cicatricial

contractions and adhesions of the vagina were hindrances in two of Simon's cases. Proximity of the ureter, which, however, Simon considers no impediment, was a feature in one of Bozeman's cases.

The author's special objections to Bozeman's method are : (1) The use of scissors instead of the knife. In all plastic operations, he says, the scissors should be used only when the knife fails. The crushing effect of even the sharpest scissors must tend decidedly to prevent union. (2) The removal of an unnecessary amount of tissue in paring the edges, particularly in the lateral cul-de-sac, where the peritoneum is liable to be wounded ; from the urethral wall, as tending to result in incontinence ; and everywhere, if the fistula be large, as adding still more to the tension to be overcome. (3) He claims that Bozeman's method of exposing the parts, although it reveals the fistula more strikingly to the eye, in reality causes their retreat, and thus renders the handling of the instruments much more difficult than in his own method, in which the parts are drawn down to, or even outside the vulva. (4) On account of the lateral expansion of the vagina, all fistulæ, even if longitudinal, have to be brought together in a transverse line. (5) Bozeman's plate suture, while undoubtedly capable of holding the parts in good apposition, is nevertheless difficult to apply ; and, on account of the concealment of the sutures by the plate during the process, there can be no certainty that each suture is accurately applied. Moreover, the sutures, being larger but less numerous, do not offer so many points of resistance to the tension ; and this resistance is therefore not sufficiently distributed.

The gradual preparatory treatment practiced by Bozeman is recommended to inexperienced operators, since it does not require the skill demanded by the rapid method. It is, however, no more efficient in most cases, many patients cannot endure it, and in some instances it exposes the patient to the danger of inflammation of the vagina, bladder, and pelvic cellular tissue, parametritis, and even pelvic peritonitis. The gradual method is sometimes necessary, however, and, as the result of observation of its employment in Bozeman's hands, Simon sets a higher value upon it now than he did before.

Amputation of the Cervix Uteri [Keilförmige Excision der Muttermundslippen mit Bildung von Seitenlappen], (F. A. Kehrer, *Archiv für Gynäkologie*, X Bd., 3 Hft., p. 431.)—After pointing out certain defects in various methods of excision of the cervix, the author lays down the following features as essential to a satisfactory method : (1) Primary union must be ensured, so far as possible, by the formation of broad, thick flaps, formed chiefly of the muscular layer of the cervix, avoiding

isolated gliding of the cervical and vaginal mucous membrane. (2) The closure of the wound must at once stop the bleeding. (3) It should enable us to remove more or less of the cervix, as required. (4) The diseased portion of the cervical mucous membrane having been removed to a sufficient extent, there should be no stenosis of the os uteri.

He details a method which he has devised to meet these requirements, and which he has performed in eighteen cases. With the patient in Sims' position, one of the lips of the os uteri, preferably the anterior, is drawn and held as low down as practicable by means of a hook or a ligature passed through it. In case of fixed uterus, the operation is not applicable. A very short speculum of horn is used. Seizing the posterior lip with a hook passed from within outwards, a piece is cut out from it in the form of a three-sided pyramid, with convex surfaces. The base of this piece, as well as its odd size (*unpaare seitenfläche*), is composed of the cervical mucous membrane, the two incisions extending deep into the parenchyma of the cervix. The upper cervical incisions, to be made first, begin two or three mm. from the lateral angles of the os externum, and run obliquely upwards and towards the median line, where they meet as an acute or right angle. The two lower incisions extend, in outwardly convex lines, to the junction of the vaginal and cervical mucous membranes, meeting at an acute angle in the middle of the lip of the os uteri. At first, these incisions are carried merely through the mucous membrane, their deep portion varying according to the amount of tissue to be removed. The flaps are brought together with sutures, which should stop the bleeding. A little bleeding, however, often continues from the upper end of the wound, which may be checked by an additional suture through the whole thickness of the lip. The sutures, left long, serve to hold the uterus during the excision of the anterior lip, which is done in the same way. The cases for which the method is recommended are: eccentric hypertrophy of the cervix, with marked swelling or ulceration of the cervical mucous membrane; hypertrophy of the cervix, with elongation of the supravaginal portion; simple elongation of the whole vaginal portion, or polypoid lengthening of one lip; and, perhaps, certain cases of cancer.

Removal of a Fibrous Tumor from the Uterus by Traction, with Remarks on the Operation, (Dr. T. A. Emmet, *Am. Jour. Obstet.*, Jan., 1877, p. 24.)—A tumor, extending above the umbilicus, and weighing, after its removal, eight pounds, occurred in a single lady, twenty-eight years old. It did not effect her general health, and, except on one occasion, when there was moderate menorrhagia, the function of menstruation was in no

wise disturbed. The os uteri being found open and the tumor presenting, showing the existence of sufficient healthy uterine tissue to drive the tumor down as successive portions should be removed, ergot was given, and the uterus kept under its influence for five days. As an odor now announced that the tumor was beginning to break down, the operation was undertaken. Failing in an attempt to pass a noose over the tumor with Gooch's canula, by which to make traction, the left index finger was passed as high up as possible behind the mass. The removal, piecemeal, with scissors, was then begun, the soft parts being protected with the finger, and a portion of the tumor drawn into view with a double hook. Although the uterus was compressing the tumor well, the latter did not advance into the vagina as usual, owing to its greater size above the superior strait. The operation was continued through the centre of the tumor until the cut surface was almost beyond reach of the instruments. The introduction of the hand became necessary, and a partial laceration of the perineum was produced. The progress of the operation was now very tedious, and the patient gave signs of approaching exhaustion, but was rallied with hypodermic injections of brandy. She was now placed in Sims' position, and his largest speculum introduced. With a large hook the lower end of the tumor, on the right side, was drawn forwards and a portion of the free surface of the tumor brought into view. Steady traction being made by an assistant, the operator was now enabled to remove with the scissors a large mass which had lodged on the brim of the pelvis. The whole circumference of the os uteri then came into view, and the contractions of the organ forced the remains of the tumor into the vagina as fast as the mass within reach could be removed. At length the attachment was reached, and found to have been reduced to a pedicle no larger than the index finger, the uterus having by its contraction displaced the tumor from its own proper tissue and closed in behind it. Traction being continued, the pedicle was divided between the labia, a partial inversion of the uterus taking place, which was at once reduced. The cervix had already begun to slough, from being compressed between the tumor and the brim of the pelvis. Hot water injections into the uterus caused rapid contraction. Although the patient was now in better condition than at one time during the operation, which lasted two hours and a half, collapse came on at the end of an hour, and she died nine hours and a half after the operation.

The author deprecates any attempt to enucleate these large tumors, as we cannot know how far the uterine tissue may have become involved. If the walls of the uterus have become too thin to contract properly,

death from hemorrhage is likely to occur before the operation is finished; if not, the subsequent danger from blood-poisoning is equally great. So soon, however, as the tumor presents through the dilating os, we have proof that a reasonable amount of uterine muscular tissue remains to aid us, and it becomes a question of judgment as to the time and mode of administering ergot. The operation should be begun when once a portion of the tumor comes to occupy the vagina,⁴ as blood-poisoning may come on within a few hours; and, when once begun, the operation should be carried on to completion, as involving the least evil and risk to the patient. When uterine contraction forces the tumor out as fast as can be removed, the operation involves little risk to life. Such contraction is excited by traction on the tumor. A blunt-pointed scissors, curved on the flat, is the preferable instrument. The *écraseur* is too slow in its action, and does not excite sufficient uterine action. It is best to pass a noose high up around the mass at first, by means of which an assistant should steady the uterus and make traction. The author thinks that, in another case like this, with the patients general health unimpaired, he would prefer a more gradual dilatation, provided the action of the uterus could be controlled. Thus a degree of tolerance might be established, and the shock of the operation lessened. Usually, however, it is advisable to dilate rapidly, and to delay the operation until the tumor begins to break down, so as to secure the greatest possible degree of dilatation and the presence of as much of the tumor as possible in the vagina.

Novel Method of Removal of Intra-Uterine Musculo-Fibrous Tumor, (Mr. G. de G. Griffith, -*Obstet. Jour. Great Britain and Ireland*, Feb., 1877, p. 734.)—The tumor, as the result of preparatory treatment, had come to occupy chiefly the vagina, which, as the patient was a virgin, was so filled by it that the operator could not encircle the tumor with a cord. He therefore crushed it with a cephalotribe, and then removed what remained of the growth with the *écraseur*.

Ovarian Dropsy; Some Points in its Pathology and Treatment. (Dr. Protheroe Smith, *Brit. Med. Jour.*, Sept. 2, 1876, p. 296.)—After expressing his opinion that the frequency of ovarian tumors may be reduced by the practice of depletion for the relief of certain menstrual disorders and symptoms due to plethora, the author states, that, while preparing his patients for oophorectomy, it has been his custom of late to take blood from the arm, not only on account of peritonitic complications, but as a preventive of inflammatory sequelæ after the operation. As regards the operation, the pedicle, if long, is best treated

with a clamp; if of moderate length, by actual cautery; but, if the cyst be close to the uterus, by ligatures. In the after-treatment, he allows little or no blood for the first five or eight days, and combats inflammatory complications by blood-letting or leeches to the uterus.

Two Cases of Ovariectomy or Spaying. (Dr. E. H. Trenholme, *Obstet. Jour. Great Britain and Ireland*, Oct., 1876, p. 425.)—In Dr. Trenholme's first case,* the removal of the normal ovaries was performed by abdominal incision, for the purpose of inducing artificial menopause in a patient thirty-two years old, the subject of uterine fibroids. The operation accomplished the desired result. Some hemorrhage occurred on two or three occasions, at times when menstruation was due, but it was treated as a hemorrhage, and soon ceased altogether. The author questions the presence of decidual debris in the periodical flow which sometimes takes place after the removal of both ovaries, and thinks that such bleeding should be checked by astringents.

In his second case, the left ovary, somewhat enlarged and prolapsed, was removed by an incision through the posterior wall of the vagina, for the relief of pain. The operation was promptly recovered from, but little if any benefit resulted to the patient.

Vaginal Ovariectomy. (Dr. C. E. Wing, *Boston Med. and Surg. Jour.*, Nov. 2, 1876, p. 516.)—In Dr. Wing's case, a retro-uterine swelling, pressing forwards upon the uterus and backwards upon the rectum, giving rise to painful defecation and marked failure of the general health, was punctured with an aspirator needle, and a diagnosis made of "fluid, old hemorrhagic effusion." A second tapping, a month or more later, was not followed by improvement, but, on the contrary, by what the author considers to have been a mild septicæmia. A thorough evacuation of the contents of the cyst being now thought necessary, Douglas's cul-de-sac was opened from the vagina, and, the finger being passed into it, a small ovarian cyst was distinctly made out. Some loose adhesions were easily broken down with the finger, the opening was enlarged, the cyst seized with the forceps, opened and evacuated, twisted to a diminished size, and pulled through into the vagina. There was no proper pedicle, but the uterus, tipping backwards, allowed the broad ligament, with the Fallopian tube, to come well into the vagina. The operator intended to apply a ligature and cut away the cyst, but at this stage his colleague, Dr. Warner, made a digital examination, and, finding the attachments loose, enucleated the tumor and brought it away. The bleeding soon ceased without ligature, and the uterus fell forwards, drawing the broad ligament back into the abdominal cavity. The wound was closed with

three silk sutures, to prevent protrusion of a coil of small intestine which appeared at the opening, room being left to pass a catheter, should there be any collection to wash out. The woman made a good recovery. On the second and third days some fetid fluid was washed out from the cul-de-sac, and on the fifth day some sloughy tissue. Complete closure of the wound occurred in about a month.

The author agrees with Peaslee, that the operation is of limited applicability, being uncalled for in cases of small tumors which can be pressed up out of the pelvis, since the number of reported cases is too small to warrant the conclusion that it is much less dangerous than abdominal oophorectomy. He admits that a large cyst, even if adherent may be removed in this way, but thinks that much greater difficulties would be met with than in the ordinary operation. He adduces a case in which the vaginal operation was recently attempted unsuccessfully by Thomas, who, being unable to make an opening into the peritoneum, on account of adhesion of the uterus to the rectum, was obliged, after opening into the rectum, to give up the operation and resort to the abdominal incision. "In another attempt to open the peritoneum from the vagina, at which I was present," says Dr. Wing, "the operator, one of our most distinguished surgeons in the country, failed completely, and was obliged to give up the attempt, although ascites was present, which theoretically should distend Douglas's cul-de-sac."

The author adds the following just remarks *apropos* of certain instances of so-called "normal ovariectomy": "Anxiety on the part of the specialist to perform great or rare operations whenever a possible chance offers is unfortunate, as nothing tends more to produce a feeling of distrust of the specialty itself among members of the profession."

Suppurating Dermoid Cysts of the Pelvic Cavity. [*Kystes Pileux Suppurés de l'Excavation Pelvienne.*] (Dr. Bernutz, *Archives de Théologie*, Oct., 1876, p. 577.)—The author gives full details of a case in which the tumor gave rise to no disturbance until soon after the patient's marriage at the age of twenty-nine (when twenty-four years old she had given birth to an illegitimate child), when it became painful. Soon after parturition, which was perfectly natural, the tumor began to give more trouble. It occupied the right iliac fossa, and extended down into the pelvic cavity, producing antelexion of the uterus, with displacement of the cervix downwards, backwards, and to the right. The patient was considerably enfeebled, and suffered from fever. An exploratory puncture showed the contents to be purulent. Several unsuccessful attempts were made to secure drainage per vaginam by introducing a long trocar

through the abdominal wall into the cyst, with the intention of pushing its point through into the vagina. It was found, however, that this could not be done without incurring the risk of transfixing the uterus. The discharge contained cheesy masses, consisting of fatty matter, together with hairs. The cyst having become adherent to the abdominal wall, the puncture was enlarged with a probe-pointed bistoury, so as to admit the finger, which detected the presence of a mass, as large as a hen's egg, made up of fatty matter and hair. With the idea of dissolving this material, the cyst was many times injected with ether. The cyst slowly contracted, but the suppuration was protracted, the pus being fetid at times. Severe constitutional disturbance was produced, and the patient's condition was precarious for upwards of four months, but she finally regained a fair state of health, although, at the date of the report, the fistula had not closed.

Case of Non-Irritable Uterus. (Dr. C. Shriver, *Cincinnati Lancet and Observer*, Sept., 1876, p. 793.)—Dr. Shriver relates the difficulties which he met with in inducing abortion at the third month. The woman had been his "patron for several years," and, "for reasons satisfactory to himself," he undertook the operation.

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Gonorrhoeal Infection in Women [Zur Lehre von der Tripperinfection beim Weibe.] (H. Fritsch, *Archiv. fur Gynaekologie*, X Bd., 3 Hft., 1876, p. 470).

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Case of Atresia Ani Vaginalis. (Dr. H. Tuck, *Boston Med. and Sur. Jour.*, Sept. 7, 1876, p. 283).

Three Cases of Imperforate Hymen. (Dr. S. R. Burroughs, *Amer. Practitioner*, Nov., 1876, p. 267).

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Atresia of the Vagina [Ein Fall von Atresia Vaginalis.] (Dohrn, *Archiv fur Gynaekologie*, X Bd., 3 Hft., 1876, p. 544).

Case of Vaginal Cyst. (Dr. D. B. Hunt, *Am. Jour. Obstet.*, Oct., 1876, p. 631).

An Unusual Recto-Vaginal Fistula. (Dr. E. Cheney, *Boston Med. and Surg. Jour.*, Nov. 23, 1876, p. 608).

Complicated Vesico-Urethro-Vaginal Fistula—Restoration of Urethra—Closure of Fistula—Cure. Dr. T. A. Emmet [reported by Dr J. D. Anway], *Am. Jour. Obstet.*, Jan., 1877, p. 74).

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Disease of the Bladder connected with Uterine Displacements. (Dr. B. McE. Emmet. (*Am. Jour. Obstet.*, Oct., 1876, p. 578).

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On the Proper Treatment for Lacerations of the Cervix Uteri. (Dr. T. A. Emmet, *Am. Practitioner*, Jan., 1877, p. 1).

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HOSPITAL RECORDS.

NEW YORK HOSPITAL.

REPORTED BY CHARLES H. KNIGHT, M. D., HOUSE SURGEON.

CALCULUS VESICAE.—MEDIAN LITHOTOMY:—SERVICE OF DR. C. M. ALLIN

John Walters, æt. 57, Englishman, admitted March 20, 1877. His symptoms began five years ago, at which time he had pain in the hypogastrium and frequent desire to urinate after unusual exertion. For the past eighteen months he has been obliged to pass water every hour or two during both the day and night. The vesical irritability is greatest in damp weather and after sexual intercourse. There was no special impairment in the general health and his habits had always been temperate. He had no suspicion of stone until within a few months.

On admission the stone searcher was introduced, and the presence of a very hard calculus was demonstrated. The urethra admitted easily No. 29½ sound. The examination was followed by no bad symptoms. The urine was examined and found to be acid, and to contain small quantities of pus.

Five days after admission Civiale's lithotrite was introduced and the stone found to measure eighteen millimetres. On the 27th an attempt was made to crush the stone with Civiale's instrument, but crushing was found to be impracticable on account of the hardness of the stone. At this grasping the diameter of the stone measured twenty-five mm.

Perineal lithotomy was then determined upon, and the median operation was the one selected. The patient was accordingly etherized and the operation done by Dr. Allin. The withdrawal of the stone required considerable force, and it was found necessary to make a slight nick with the knife in the anterior margin of the prostate. This was followed by moderate hemorrhage, which, however, was soon checked by means of ice and pressure.

The stone consisted of oxalate of lime, and weighed 140 grs.

The patient passed water through the meatus at 11 P. M. and continued to pass urine at intervals, in this way and by the perineum until the third day, when it ceased to come by the meatus. The patient had a slight chill on the day after the operation, but otherwise had no bad symptoms, the temperature never rising above 100°. The patient took freely of decoction of triticum repens both previous to, and after the operation, with apparent relief of irritability of the bladder.

REMARKS.—The median operation was selected in this case, as the size of the stone seemed to indicate a favorable chance for its easy extraction by this method. With many surgeons the propriety of performing the median operation usually hinges on the size of the calculus. Stones which measure less than 13–16 of an inch (or 20 mm.), in diameter may readily be removed, as the prostatic urethra can easily be stretched to the extent of 20 mm. without any laceration. We are of the opinion that it may be performed with as much safety when the calculus is much larger.

It is now generally admitted that the median operation possesses many obvious advantages over all other methods of perineal lithotomy where the stone is small, and the only objection of consequence now made to the operation is that it is not suitable to stones of large size. The objection carries with it no weight, for it is a simple matter to crush the stone with proper instruments, before its removal.

The main point however in discussing questions of this nature is the mortality of the various operations, and in this respect none of them can compare with the median. If statistics prove anything, they show conclusively that it is by far the safest method. According to Gross,* an avowed champion of the lateral method, "of 2303 cases of lateral lithotomy in the hands of American surgeons 156 or about 1 in 14 died." In the case of median lithotomy among American surgeons† "of 205 cases 9 or 1 in 22.77 died."

CASE OF SUPRAPUBIC DISLOCATION OF FEMUR.—SERVICE OF DR. ALLIN.

M. M. aet. 62, Ireland, waiter. Admitted March 27th, 1877.

While going up stairs he fell down five or six steps. Can not say how he fell or what part of the body struck first. On admission the left leg was everted, the knee flexed, and the limb shortened $\frac{3}{4}$ in. The head of the femur was found just below and to the inner side of the anterior superior spinous process of the ilium. Attempts at reduction by manipulation, under ether, failed, and on the following day reduction was accomplished by means of extension with compound pulleys. There was some oedema of the leg next day, but not much pain. The legs were kept bandaged together for 24 hours and evaporating lotions applied. Passive motion was made gently on the 2nd of April.

REMARKS.—The preceding case is one of considerable interest on account of its being the rarest of the four usual varieties of dislocation of

*Gross on the Urinary Organs, 3rd edition, 1876, p. 275.

†Ibid. p. 290.

the femur. According to the standard authorities it occurs only once in every twenty cases of luxation of this bone.

In the present case it was found impossible to reduce it by manipulation and this was probably owing to the firmness with which the head of the bone was held by Poupart's ligament, the head being undoubtedly wedged between it and the brim of the pelvis.

UNIVERSITY HOSPITAL, BALTIMORE.

REPORTED BY T. A. ASHEY, M. D., RESIDENT SURGEON.

CALCULUS OF THE URETHRA—SERVICE OF DR. L. Mc. L. TIFFANY.

B. F. W. æt. 32, occupation a baggage master, had suffered for two years with what he supposed to be a stricture of the urethra. Two weeks before applying for treatment at the hospital his trouble increased to such an extent as to cause great difficulty in the passage of urine. He applied for treatment to the physicians at his home in Penn. An examination was made and the presence of a stone was detected in the urethra just in front of the triangular ligament. Every effort to remove it short of an operation proved useless. The attempted use of catheter produced such inflammation that the passage of urine was entirely prevented and paracentesis was twice performed just above the symphysis, and urine removed.

He was then sent to Baltimore and admitted into this hospital. When reaching the hospital there was great distress from distention, as also a peritonitis from previous use of the aspirator. After a few unsuccessful attempts at the removal of the calculus through the urethra the patient was anaesthetized and an incision made through the perineum into the urethra, through which the calculus was withdrawn. After the removal of the calculus all effort to reach the bladder proved unavailing and it became necessary to use the aspirator a third time.

The patient was placed in bed and one gr. of opium was administered every two hours during the night. On the following morning ten grains of quinine were administered and opium in one grain doses every two hours during the day.

The patient was placed in a hot hip bath the following night, and after remaining in water half an hour was enabled to pass his urine in a small stream through the urethra and incision.

Ten grains of quinine were given again at night, with opium in gram

doses every two or three hours. Hot turpentine stupes were kept over the hypogastrium during the entire night. On the third day the patient was much better and after being placed in a hot hip bath succeeded in passing his urine in a larger stream than the day before. Quinine and opium were continued during the third day, with hot turpentine stupes. Hot baths administered again at bed time. On fourth day after operation patient passed urine without use of hip bath in very small stream, a portion coming through the perineal wound and the remainder through the urethra. Inflammatory symptoms subsided and patient gradually improved so as to be able to return home on the tenth day after the operation. Previous to leaving the hospital every effort at an introduction of a catheter failed, but a small Phillip's whalebone guide was introduced with difficulty. The patient left the hospital before a perfect cure was effected, but so far relieved as to be able to pass urine in a medium sized stream through the penis and perineal wound without great difficulty.

The pathological condition in this case was most probably this; a calculus formed in the urethra behind which existed a stricture. Inflammation resulting from the use of instruments, the orifice of the urethra was entirely closed and every effort at micturition prevented.

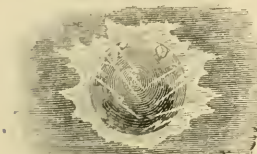
This is shown by the size and character of the calculus and the condition of the urethra on either side of the sac in which the stone was nested.

The calculus was about $\frac{3}{4}$ of an inch in length and $\frac{1}{2}$ in diameter, oval in shape and formed of uric acid.

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NOTE.—Our review of Dr. Sayre's work on "Orthopedic Surgery and Diseases of the Joints" seems to have called forth considerable discussion, and the parties more immediately interested are inclined to continue the controversy and carry it on upon personal grounds, rather than as a scientific discussion. We are in receipt of many communications, some intended for our editorial ear alone, and others which the authors desire to have published in the ARCHIVES. We think that it would be doing a marked injustice to our readers to protract this matter further, and must therefore decline to receive, for publication, any more communications in reference to the subject. In adopting this course, we are aware that we leave ourselves open to the charge of partiality, especially in reference to Dr. Sayre, who, in his letter published in our March number, declined to be called an associate of Dr. Bauer, on the ground that he had proved him guilty of falsehood. It seems only right that Dr. Bauer should have a hearing when such a grave charge is preferred against him, and we should willingly accord him all the requisite space did we not feel convinced that this point had been settled long since, (vide *New York Med. Jour.*, Nos. 1 and 2, 1869.)—ED.

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